ClassicSleepCare LLC
Healthy Sleep. Beautiful Smiles.

Request for an Accounting of Disclosures Form

The purpose of this form is to request an accounting of disclosures of protected health information made by our organization.

Date of Request: _____

Information on Person Requesting Accounting

Patient Name: _____ Date of Birth: _____

Patient Address: _____

_____

Medical Record/Set: _____

Timeframe of Request

I would like to request a complete accounting of all disclosures made during the following time frame:

From Date: _____ To Date: _____

[Note: The maximum time frame of request cannot exceed six years prior to request date above.]

Fees for Request

The first request in a 12 month period will be provided free of charge. For all subsequent requests the fee will be: _____ with the cost of this request being: _____.

Acknowledgment of Request

I hereby acknowledge the above request and understand that I will be responsible for the payment of the above fee (if any) in connection with this request.

_____ _____

Signature of Patient or Legal Patient Representative *Date*

[Note: All requests will be provided to me within 60 days, unless an extension is required in which case I will be notified in writing. In any case, my request will not take longer than 90 days to fulfill.]

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[Do Not Write in Section Below – For Healthcare Provider Use Only]

Assigned To: _____ Date Delivered to Patient:_____

Extension Requested: [ ] Patient Notified: [ ] Date Notified:_____

Reason: _____